Dr. Mark H. Schecker
Allergist

# Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

Dear New Patient:

We look forward to meeting you on _____ at _____ in our office.

Coastal Carolina Allergy & Asthma Associates, P.C. appreciates your selection of this office to serve your Allergy and Asthma needs, and will do everything possible to provide you with the very best of care. In order to do so, we ask that you please review the enclosed information sheets carefully. We have attempted to give you as much information about our practice as possible and to anticipate your questions and needs regarding our policies and procedures.

The need for allergy skin testing will be determined at your initial visit, and may be done that day if appropriate. If not it will be scheduled at another time. If skin testing is done, results will be available immediately. Some medications may need to be stopped before skin testing appointments. Never stop any medication without first consulting this office or the prescribing physician.

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**COASTAL CAROLINA ALLERGY AND ASTHMA ASSOCIATES, P.C.**
**3516 CADUCEUS DRIVE**
**MYRTLE BEACH, SC 29588**
**PHONE # (843) 293-0093**
**DR. MARK SCHECKER**

Dear Patients,

We are writing to provide you with important information regarding our billing policies. Please take a minute or two to read this letter.

Our practice relies on the timely payment of the fees charged for services we provided you in order to continue to provide you with quality care. Although we currently bill several health insurance companies, as well as Medicare and Medicaid, the responsibility of the account balance lies with the patient. In the case of a child who is the patient, the payment responsibility lies with the child's parents or guardians.

The fee for an initial office visit ranges from $90.00 to $430 depending on the type and complexity of the medical condition. There are additional fees for allergy testing and other diagnostic services. The cost of testing and diagnostics services is determined by the nature of the problem. These fees range from $80.00 to $910.00.

When no health insurance is available to pay these charges, the patient is required to remit payment in full. If a patient has health insurance they are expected to pay their insurance company's contracted amount at the time of the office visit. If you believe you have met your health insurance deductible we require you to provide our office with written verification that the deductible has been met.

**It is every patient's responsibility to check with their health insurance company prior to their visit to obtain a full explanation of their covered benefits for allergy care.** If there are questions about the billing of health insurance, please call our business office to discuss this with them.

The importance of **bringing your insurance card with you to each office visit** cannot be over-emphasized. If you are enrolled in a health insurance program that requires a primary care physician referral, you are responsible for obtaining the referral and bring it with you.

Patients may continue to pay by cash, check with proper identification, MasterCard, VISA, American Express and Discover. If a bank returns a check to our office for insufficient funds we will attempt to collect the funds from the bank two times. If your account still does not have sufficient funds after those attempts, the amount due will be charged back to your account. An administrative service charge of $30 will be applied for each check returned due to insufficient funds.

Lastly, if you are unable to make a scheduled appointment, please notify our office **24 hours in advance**. If you are running 15 or more minutes late for your scheduled appointment please call our office for possible rescheduling. If you do not, we may <u>not</u> be able to work you in the schedule that day.

Thank you for entrusting us with your medical care. If you have any questions, or would like to discuss our billing policies, please don't hesitate to give us a call.

**COASTAL CAROLINA**
**ALLERGY & ASTHMA**

# ABOUT ALLERGY

Dear Patient:

If the doctor determines that you may be allergic he will order testing to find out what specific sensitivities you may have. Therefore, if testing is ordered for you, you should know the following. Each testing session is done in one or two stages depending on what has been ordered. The initial testing, called the prick method, is done on the back. After waiting a period of 15–20 minutes the area is checked for reactions that may have occurred. Any item that does not react during the initial testing is retested on the arm by the intradermal method. The intradermal method requires the injection of a very small amount of the allergen into the superficial layers of the skin. Reactions are evidenced by areas of swelling (wheals), redness, and itching. People who are highly allergic may have local reactions that take several days to disappear, however, the large majority are resolved within 30 minutes.

There are certain medications that interfere with allergy testing. Therefore, you will be given an abbreviated list of medications you can and cannot take before testing. On rare occasions a patient may experience a more severe reaction to testing, which may consist of the following: itching (especially of the ears and scalp), asthma, hives, weakness, dizziness, and nausea. When such reactions occur they are readily treated by our doctor.

*COASTAL CAROLINA*
*ALLERGY & ASTHMA*

## *Skin Testing*

*Allergy and Asthma patients for whom allergy skin testing is found to be necessary must not use antihistamine compounds prior to the skin test appointment. These compounds include not only the "classic" antihistamines but also certain compounds with "antihistamine-like activity" such as the tricyclic antidepressants. These will be mentioned in the ensuing paragraphs.*

*NO PRESCRIPTION OR OVER THE COUNTER ANTIHISTAMINES SHOULD BE USED FOR 5 DAYS PRIOR TO THE SCHEDULED SKIN TESTING. THESE INCLUDE COLD TABLETS, SINUS TABLETS, HAY FEVER MEDICATIONS, OR ORAL TREATMENTS FOR ITCHY SKIN. THEREFORE, IT IS IMPORTANT TO READ THE PACKET LABEL. SOME OF THE NAMES OF THESE DRUGS INCLUDE ACTIFED, DRIXORAL, DIMETAPP, DRISTAN, ORNADE, BENADRYL, RONDEC, TRINALIN, CLARITIN(LORATADINE), ZYRTEC(CETIRIZINE), ASTELIN(AZELASTIN), ALLEGRA(FEXOFENADINE), AND MANY OTHERS.*

*As noted, certain other medications will also interfere with skin testing because they have "antihistamine-like" properties. These would include the tricyclic antidepressants (elavil/adapin/sinequan/surmontil/tofranil/amitrptyline/etc.). If you are taking one of these types of medications or certain tranquilizers, please notify us so that we can determine whether skin testing can be done.*
*THESE MEDICATIONS SHOULD NOT BE STOPPED UNLESS YOU HAVE DISCUSSED IT WITH US.*

*If your condition requires continuous administration of any of the above medications or if you have a question about a certain medication, please notify us so that we may discuss this with you and determine whether skin testing needs to be postponed.*

*You may continue to use plain decongestants (Sudafed, Entex) nasal steroid sprays (Nasonex, Rhinocort, Beconase, Nasocort, Vancenase, Nasalide), nasal cromolyn (Nasalcrom), and any antibiotics.*
*THESE WILL NOT INTERFERE WITH YOUR SKIN TESTING.*

*Asthma inhalers (Intal,beclomethasone (Beclovent, Vanceril), Aerobid, Flovent, Pulmicort, Advair, Serevent, Alupent, Brethaire, albuterol (Proventil, Ventolin) and oral theophylline (Theo-Dur, T-Phyl, Uniphyl) and oral albuterol do not interfere with skin testing and should be used as prescribed.*

*(OVER)*

*Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking.*
*Please let the physician and nurse know:*

1. *If you are taking any beta blockers or antidepressants.*
2. *If you are pregnant.*
3. *If you have a fever or wheezing.*
4. *Any medications you are taking (bring a list if necessary).*

*After skin testing, you will meet with your physician who will make further recommendations regarding your treatment.*

***PLEASE DO NOT CANCEL YOUR APPOINTMENT SINCE THE TIME SET ASIDE FOR YOUR SKIN TEST IS EXCLUSIVELY YOURS FOR WHICH SPECIAL ANTIGENS ARE PREPARED. IF FOR ANY REASON YOU NEED TO CHANGE YOUR SKIN TEST APPOINTMENT, PLEASE GIVE US AT LEAST 48 HOURS NOTICE. DUE TO THE LENGTH OF TIME SCHEDULED FOR SKIN TESTING, A LAST MINUTE CHANGE RESULTS IN LOSS OF VALUABLE TIME THAT ANOTHER PATIENT MIGHT HAVE UTILIZED.***

Coastal Carolina Allergy & Asthma Associates
Mark Schecker MD

Specializing in the treatment of Allergy, Asthma, Sinus Disease & Clinical Immunology in children and adults.

ANTIHISTAMINES INTERFERE WITH SKIN TESTING AND SHOULD BE STOPPED 5 DAYS IN ADVANCE. THE FOLLOWING IS A PARTIAL LIST OF SOME COMMON ANTIHISTAMINES:

**ACTIFED**
**ALLEGRA / ALLEGRA D**
**ALLEREST**
**ALLERX**
**ANTIVERT**
**ASTELIN**
**ASTEPRO**
**BENADRYL**
**CHLORTRIMETON**
**CLARINEX / CLARINEX D**
**CLARITIN / LORATADINE**
**CLARITIN D**
**DIMETAPP**
**DRISTAN**
**DRIXORAL**
**LODRANE**
**MECLIZINE**
**PALGIC**
**PATADAY**
**PATANASE**
**PERIACTIN**
**PHENERGAN**
**RESPA HIST**
**RONDEC**
**RU-TUSS**
**RYNATAN**
**SINAREST**
**TAVIST / CLEMASTINE**
**TRIAMINIC**
**TUSSIONEX**
**TYLENOL ALLERGY SINUS**
**TYLENOL PM**
**XYZAL/ LEVOCETIRIZINE**
**ZYRTEC / ZYRTEC D/CETIRIZINE C**

SOME ALLERGY EYEDROPS ALSO CONTAIN ANTIHISTAMINES AND SHOULD BE STOPPED. SOME OF THESE AVAILABLE BY PRESCRIPTION ARE **PATADAY, PATANOL, OPTIVAR,** AND **BEPREVE**. OVER THE COUNTER EYE DROPS FOR ALLERGY MAY ALSO CONTAIN ANTIHISTAMINE. IF YOU ARE NOT SURE ABOUT ANY MEDICATIONS PLEASE CALL OUR OFFICE FOR ASSISTANCE.

YOU CAN CONTINUE TO TAKE DECONGESTANTS SUCH AS **SUDAFED,** PRESCRIPTION STEROID NASAL SPRAYS (E.G. NASONEX, FLONASE) ASTHMA MEDICATIONS, PREDNISONE, AND ANTIBIOTICS.

**THIS LIST MAY NOT BE COMPLETE. IF YOU HAVE ANY QUESTIONS ABOUT THE MEDICATIONS YOU ARE TAKING, PLEASE CONTACT OUR OFFICE FOR ASSISTANCE.**

COASTAL CAROLINA ALLERGY & ASTHMA ASSOCIATES, P.C.

## Allergy Questionnaire Instructions

Please fill out the questionnaire completely and accurately. It is an important part of your evaluation, aiding the collection and organization of information about your problems.

The questionnaire is best filled out at home where labels can be checked to determine such items as stuffing materials in pillows and cushions, and the name and dosage of medicines you are taking.

If there are any questions concerning this questionnaire, or other concerns, please call (843) 294-9494. Please bring these forms and your medicines with you for your appointment with Dr. Schecker.

**If you find you are unable to make your scheduled appointment, please call our office twenty-four (24) hours before the scheduled time. We set aside time to be available to you and expect you to extend to us the same courtesy.**

# ALLERGY QUESTIONNAIRE

PLEASE PRINT CLEARLY

| NAME (LAST) (FIRST) | | | DATE |
|---|---|---|---|
| BIRTHDATE | SEX ☐ MALE ☐ FEMALE | MEDICAL RECORD NUMBER | |
| ADDRESS (STREET) | (CITY) | (ZIP CODE) | |
| HOME PHONE ( ) | WORK PHONE / DAY PHONE ( ) | OCCUPATION | |
| WHO IS YOUR REGULAR PHYSICIAN? | | HOBBIES | |
| MARITAL STATUS ☐ NOT MARRIED ☐ MARRIED | IF MARRIED, SPOUSE'S OCCUPATION | | SPOUSE'S HOBBIES |
| HOW MANY YEARS HAVE YOU LIVED IN S. CAROLINA ☐ | INDICATE OTHER CITIES OF RESIDENCE AND YEARS LIVED THERE | | |

## IF PATIENT IS A CHILD, COMPLETE THE FOLLOWING

| | | | |
|---|---|---|---|
| FATHER'S COMPLETE NAME | AGE | OCCUPATION | HOBBIES |
| MOTHER'S COMPLETE NAME | AGE | OCCUPATION | HOBBIES |

## INDICATE THE MAJOR REASON(S) FOR ALLERGY REFERRAL

☐ 1. HAYFEVER ☐ 4. EAR PROBLEMS ☐ 7. HIVES ☐ 10. RECURRENT INFECTION

☐ 2. SINUS ☐ 5. BRONCHITIS ☐ 8. ECZEMA ☐ 11. REACTION TO INSECTS

☐ 3. ASTHMA ☐ 6. EYE PROBLEMS ☐ 9. DRUG ALLERGY ☐ 12. OTHER _____

## IN YOUR OWN WORDS, DESCRIBE THE MOST DISTRESSING SYMPTOMS YOU FEEL ARE CAUSED BY YOUR ALLERGY?

## ABOUT HOW OLD WERE YOU WHEN YOUR ALLERGY PROBLEM(S) BEGAN?

## HOW DOES YOUR ALLERGY PROBLEM AFFECT YOUR LIFE?

## SYSTEMS REVIEW *(CHECK ONLY BOXES FOR WHICH A PROBLEM EXISTS)*

| | HOW MUCH | | | HOW OFTEN? | | |
|---|---|---|---|---|---|---|
| **EARS** | *MILD* | *MODERATE* | *SEVERE* | *RARELY* | *OCCASIONALLY* | *DAILY* |
| ITCHING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EAR INFECTIONS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DRAINING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BLOCKED | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| POPPING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HEARING PROBLEMS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **EYES** | *MILD* | *MODERATE* | *SEVERE* | *RARELY* | *OCCASIONALLY* | *DAILY* |
| TEARING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ITCHING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SWELLING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| PAIN | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BLURRED VISION | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **NOSE/SINUSES** | *MILD* | *MODERATE* | *SEVERE* | *RARELY* | *OCCASIONALLY* | *DAILY* |
| ITCHING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SNEEZING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CLEAR MUCUS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| COLORED MUCUS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| PLUGGED OR BLOCKED | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| POST NASAL DRIP | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| NOSE BLEEDS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SNORING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MOUTH BREATHING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| LOSS OF SMELL | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

HAVE YOU EVER HAD SINUS X-RAYS?

☐ NO ☐ YES; *INDICATE APPROXIMATE DATE* ☐

WHAT WERE RESULTS?

| | HOW MUCH | | | HOW OFTEN? | | |
|---|---|---|---|---|---|---|
| **THROAT/MOUTH** | *MILD* | *MODERATE* | *SEVERE* | *RARELY* | *OCCASIONALLY* | *DAILY* |
| BAD BREATH | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ITCHING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| PAIN | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| FREQUENT TONSILLITIS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HOARSENESS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| COLD SORES | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SWALLOWING PROBLEMS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SWOLLEN GLANDS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

AGE OF ONSET OF PROBLEMS WITH: EARS ☐ EYES ☐ NOSE ☐ THROAT ☐

OTHER PROBLEMS WITH EYES, EARS, NOSE OR THROAT

| | HOW MUCH | | | HOW OFTEN? | | |
|---|---|---|---|---|---|---|
| **CHEST PROBLEMS** | *MILD* | *MODERATE* | *SEVERE* | *RARELY* | *OCCASIONALLY* | *DAILY* |
| ASTHMA | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| WHEEZING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| COUGHING | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| TIGHTNESS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SHORTNESS OF BREATH | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CONGESTION | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

AGE AT BEGINNING OF PROBLEM(S) ☐

NUMBER OF EMERGENCY VISITS FOR ASTHMA — PAST YEAR ☐ LIFETIME ☐

HOW OFTEN ARE YOU AWAKENED BY ASTHMA?
☐ NEVER ☐ MONTHLY ☐ WEEKLY ☐ NIGHTLY

NUMBER OF TIMES HOSPITALIZED FOR ASTHMA — PAST YEAR ☐ LIFETIME ☐

NUMBER OF DAYS MISSED FROM WORK OR SCHOOL DUE TO ASTHMA IN THE PAST YEAR ☐

DO YOU CHOKE OR VOMIT FREQUENTLY?
☐ NO ☐ YES

DID YOU HAVE SEVERE OR FREQUENT BRONCHIAL INFECTIONS
*CHILD?* ☐ NO ☐ YES *ADULT?* ☐ NO ☐ YES

HAVE YOU HAD PNEUMONIA?
☐ NO ☐ YES NUMBER OF TIMES ☐

INDICATE IF YOU HAVE LIMITED PHYSICAL ACTIVITY DUE TO ASTHMA
☐ NONE ☐ OCCASIONAL ☐ RARELY ☐ DAILY

DO YOU OR HAVE YOU EVER SMOKED?
☐ NONE ☐ PAST ☐ PRESENT; *HOW MANY PACKS A DAY?* ☐

HOW MANY YEARS HAVE YOU SMOKED? ☐

DO YOU WANT TO STOP SMOKING? ☐ YES ☐ NO

*IF YOU HAVE QUIT SMOKING*, HOW MANY YEARS HAS IT BEEN? ☐

CHECK APPROPRIATE BOX(ES) FOR THINGS THAT MAKE YOU FEEL WORSE

| WHICH MONTHS OF THE YEAR ARE THE PATIENTS SYMPTOMS WORSE: | HAYFEVER OR NASAL SYMPTOMS | CHEST ASTHMA BRONCHITIS | OTHER SYMPTOMS (PLEASE SPECIFY) |
|---|---|---|---|
| SAME ALL YEAR | ☐ | ☐ | |
| SPRING (MAR-APR-MAY) | ☐ | ☐ | |
| SUMMER (JUN-JUL-AUG) | ☐ | ☐ | |
| AUTUMN (SEP-OCT-NOV) | ☐ | ☐ | |
| WINTER (DEC-JAN-FEB) | ☐ | ☐ | |
| HOUSE DUST | ☐ | ☐ | |
| MOWED GRASS | ☐ | ☐ | |
| RAKING LEAVES | ☐ | ☐ | |
| WINDY DAYS | ☐ | ☐ | |
| YARDS OR PARKS | ☐ | ☐ | |
| WEATHER CHANGES | ☐ | ☐ | |
| DAMONESS | ☐ | ☐ | |
| HEAT | ☐ | ☐ | |
| COLD | ☐ | ☐ | |
| AIR CONDITIONING OR DRAFTS | ☐ | ☐ | |
| NEWSPAPERS | ☐ | ☐ | |
| IRRITANT FUMES OR AEROSOLS | ☐ | ☐ | |
| SMOKE | ☐ | ☐ | |
| SMOG | ☐ | ☐ | |
| COSMETICS OR PERFUMES | ☐ | ☐ | |
| RAIN | ☐ | ☐ | |
| EXERCISE | ☐ | ☐ | |
| EMOTIONAL UPSET (CRYING) | ☐ | ☐ | |
| LAUGHING | ☐ | ☐ | |
| NIGHT TIME OR SLEEP | ☐ | ☐ | |
| ON AWAKENING | ☐ | ☐ | |
| AT WORK | ☐ | ☐ | |
| AT PLAY | ☐ | ☐ | |
| AT SCHOOL | ☐ | ☐ | |
| ON VACATION | ☐ | ☐ | |
| CATS | ☐ | ☐ | |
| DOGS | ☐ | ☐ | |
| BIRDS OR FETHERS | ☐ | ☐ | |
| DRIED FRUITS | ☐ | ☐ | |
| RESTAURANT MEALS | ☐ | ☐ | |
| BEER OR WINE | ☐ | ☐ | |
| MENSTRUAL PERIOD | ☐ | ☐ | |
| EGGS | ☐ | ☐ | |
| MILK OR DAIRY PRODUCTS | ☐ | ☐ | |
| NUT | ☐ | ☐ | |
| PEANUT | ☐ | ☐ | |
| SHELLFISH(SHRIMP/LOBSTERS/CLAMS) | ☐ | ☐ | |
| FISH | ☐ | ☐ | |
| OTHER | ☐ | ☐ | |
| OTHER | ☐ | ☐ | |
| MOUNTAIN TRIPS | ☐ | ☐ | |
| DESERT TRIPS | ☐ | ☐ | |
| BEACH TRIPS | ☐ | ☐ | |
| AWAY FROM HOME | ☐ | ☐ | |
| AWAY FROM WORK | ☐ | ☐ | |
| AIR CONDITIONING | ☐ | ☐ | |
| SWIMMING | ☐ | ☐ | |
| EXERCISE | ☐ | ☐ | |
| OTHER | ☐ | ☐ | |
| OTHER | ☐ | ☐ | |

## INDICATE MEDICATIONS YOU ARE NOW TAKING FOR ALLERGY AND ASTHMA.
*(PLEASE BRING THEM WITH YOU FOR YOUR FIRST APPOINTMENT)*

| | 1. | 2. | 3. | 4. | 5. | 6. |
|---|---|---|---|---|---|---|
| NAME OF MEDICATION | | | | | | |
| DOSE OR STRENGTH | | | | | | |
| DOSES TAKE DAILY | | | | | | |
| SIDE EFFECTS | | | | | | |
| DOES TAKING THIS MEDICATION HELP? | ☐ NO ☐ YES ☐ SOMETIMES | ☐ NO ☐ YES ☐ SOMETIMES | ☐ NO ☐ YES ☐ SOMETIMES | ☐ NO ☐ YES ☐ SOMETIMES | ☐ NO ☐ YES ☐ SOMETIMES | ☐ NO ☐ YES ☐ SOMETIMES |

INDICATE NAMES OF ALLERGY OR ASTHMA MEDICINES THAT WERE TRIED BUT DID NOT WORK OR CAUSED SIDE EFFECTS

INDICATE OTHER MEDICINES OFTEN USED *(INCLUDE ASPIRIN, NOSE SPRAYS, BIRTH CONTROL PILLS, VITAMINS).*

ARE YOU ON A BETA-BLOCKER DRUG FOR YOUR HEART, BLOOD PRESSURE, EYES OR HEADACHES? ☐ NO ☐ YES IF YES, WHICH ONE?

## MEDICAL HISTORY AND APPROXIMATE DATES

HISTORY OF ALLERGY OR RESPIRATORY PROBLEMS IN INFANCY OR CHILDHOOD

☐ MILK OR OTHER FOOD ALLERGY ☐ ECZEMA ☐ ASTHMA ☐ CROUP ☐ BRONCHIOLITIS ☐ OTHER

GENERAL HEALTH
☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

WEIGHT IN THE PAST YEAR
☐ STABLE ☐ GAIN ☐ LOSS

MEDICAL ILLNESSES
☐ HEART DISEASE ☐ ARTHRITIS ☐ TB
☐ ULCERS ☐ GLAUCOMA ☐ DIABETES

CHILDHOOD IMMUNIZATIONS
☐ UP TO DATE ☐ INCOMPLETE

WERE THERE ANY UNUSUAL REACTIONS TO IMMUNIZATIONS?

OTHER MEDICAL CONDITIONS

PAST HOSPITALIZATIONS *(GIVE APPROXIMATE YEAR AND REASON)*

## INDICATE OPERATIONS YOU HAVE HAD AND THE APPROXIMATE DATES

☐ TUBES IN THE EARS DATE
☐ TONSILLECTOMY AND/OR ADENOIDECTOMY DATE
☐ SINUS SURGERY DATE
☐ REMOVAL OF NASAL POLYPS DATE
☐ NASAL SEPTUM REPAIR DATE
☐ CHEST SURGERY DATE

## SKIN

ECZEMA - WHAT MAKES IT WORSE?

HIVES AND/OR SWELLING - WHAT TRIGGERS IT?

OTHER SKIN PROBLEMS

☐ DRY ☐ SMALL BUMPY RASH ☐ ITCHY RASH ☐ EASY BRUISING ☐ REACTION TO METALS ☐ CHEMICALS ☐ COSMETICS ☐ OTHER

## FOOD ALLERGIES

INDICATE FOOD(S) YOU ARE ALLERGIC TO AND THEIR REACTION(S)

ADDITIONAL FOOD ALLERGY COMMENTS *(INDICATE TYPE OF REACTION(S) AND APPROXIMATE AGE)*

## DRUG ALLERGIES

☐ ASPIRIN ☐ LOCAL ANESTHETIC ☐ SULFA
☐ PENICILLIN ☐ X-RAY DYES ☐ OTHER_____

ADDITIONAL DRUG ALLERGY COMMENTS

## REACTIONS TO INSECTS

☐ BEE ☐ WASP ☐ YELLOWJACKET
☐ HORNET ☐ ANT ☐ OTHER STINGING INSECT

TYPE OF REACTION

## STOMACH OR INTESTINAL PROBLEMS

☐ POOR APPETITE ☐ NAUSEA ☐ ULCERS ☐ BLACK OR BLOODY BOWEL MOVEMENTS
☐ VOMITING ☐ DIARRHEA ☐ PAIN ☐ HEARTBURN ☐ OTHER_____

## FAMILY ALLERGY HISTORY

| | HAYFEVER OR NASAL SYMPTONS | SINUS | ASTHMA | CHRONIC LUNG DISEASE OR EMPHYSEMA | FOOD ALLERGY | HIVES OR SWELLING | ECZEMA |
|---|---|---|---|---|---|---|---|
| MOTHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| FATHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BROTHERS OR SISTERS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CHILDREN | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

ARE THERE GRANDPARENTS, AUNTS OR UNCLES WITH ALLERGY PROBLEMS? ☐ NO ☐ YES *IF YES, EXPLAIN*

## CHECK OR COMPLETE THE ANSWERS THAT BEST DESCRIBE YOUR HOME ENVIRONMENT

**TYPE OF HOME**
☐ APARTMENT ☐ DORMITORY ☐ MOBILEHOME
☐ HOUSE ☐ CONDOMINIUM

**LOCATION OF HOME**
☐ SEASHORE ☐ MOUNTAIN ☐ CITY
☐ COUNTRYSIDE ☐ DESERT

**AGE OF HOME**
AGE IN YEARS ____

**IS THERE OBVIOUS?**
☐ MILDEW OR WATER DAMAGE ☐ ROACHES

**DO YOU HAVE?**
☐ SPACE HEATER ☐ ROOM AIR PURIFIER ☐ EVAPORATIVE COOLER ☐ CENTRAL AIR CONDITIONING
☐ ROOM HUMIDIFIER ☐ CENTRAL HUMIDIFIER ☐ CENTRAL AIR PURIFIER ☐ CENTRAL HEATING ☐ FIREPLACE

**BEDROOM HAS**
☐ HEATING ☐ AIR CONDITIONING
☐ HUMIDIFIER ☐ AIR PURIFIER

**TYPE OF BEDROOM FLOOR COVERING**
☐ CARPET ☐ LINOLEUM OR TILE
☐ WOOD ☐ OTHER

**BED TYPE**
☐ MATTRESS AND BOX SPRING ☐ WATER BED AGE OF BED IN YEARS ____
☐ ZIPPERED COVER ☐ MATTRESS ONLY

**BEDROOM WINDOW IS**
☐ OPEN ☐ CLOSED *AT NIGHT*

**TYPE OF PILLOWS YOU HAVE**
☐ FEATHER ☐ DACRON/SYNTHETIC
☐ FOAM RUBBER ☐ ZIPPERED COVER/PLASTIC *AGE IN YEARS* ____

**TYPE OF BLANKET/COMFORTER**
☐ FEATHER ☐ SYNTHETIC
☐ OTHER ____

**IS THERE A SMOKER IN YOUR RESIDENCE?**
☐ NO ☐ YES *IF YES, RELATIONSHIP:*

***IF YOU SMOKE,* WHERE DO YOU SMOKE?**
☐ IN HOUSE ☐ AT WORK
☐ IN CAR ☐ OUTDOORS

**INDICATE INDOOR PETS YOU HAVE**
☐ CAT ☐ DOG
☐ BIRD ☐ OTHER

**INDICATE WHICH ANIMALS YOU ARE EXPOSED TO (OTHER THAN HOME)**
☐ HORSE ☐ DOG
☐ CAT ☐ BIRD(S)

**INDICATE WHERE YOU ARE EXPOSED TO PETS**
☐ HOME ☐ SCHOOL ☐ DAYCARE OR BABYSITTER
☐ WORK ☐ RELATIVES ☐ PATIENT'S BEDROOM ☐ FRIENDS

**INDICATE IF ANY OF THE FOLLOWING ARE OUTSIDE YOUR HOME**
☐ WOOD SHEDS ☐ FIREWOOD ☐ OPEN FIELD ☐ HAY
☐ CHICKEN COOPS ☐ BARNS ☐ STABLES

**DOES YOUR MOTOR HOME HAVE AIR CONDITIONING?**
☐ YES ☐ NO *IF YES, DO YOU USE IT FREQUENTLY?* ☐ YES ☐ NO

## ADDITIONAL COMMENTS PERTAINING TO HOME ENVIRONMENT

## PAST ALLERGY EVALUATION/TREATMENT

*INDICATE TYPE OF ALLERGY TESTS TAKEN BEFORE* ☐ NONE ☐ BLOOD ☐ SKIN ☐ OTHER

*INDICATE WHAT THE TESTS WERE POSITIVE TO* ☐ POLLENS ☐ MOLDS ☐ FOODS ☐ OTHER ____ ☐ DUST ☐ ANIMALS ☐ DRUGS

*HAVE YOU EVER RECEIVED CORTISONE-LIKE DRUGS (PREDNISONE, DECADRON, STEROIDS)?* ☐ NO ☐ YES *IF YES, DATES* ____ *DOSE* ____ *HOW LONG?* ____

*HAVE YOU RECEIVED ALLERGY SHOTS?* ☐ NO ☐ YES IF YES, WHEN? *DATES FROM* ____ *TO* ____

*HOW HELPFUL WERE THE SHOTS?* ☐ MINIMAL HELP ☐ REACTIONS ☐ HELPFUL ☐ NO HELP

*NAME AND LOCATION OF DOCTOR WHO GAVE YOU SHOTS?*

*IS THERE CURRENTLY AN ALLERGIST TAKING CARE OF A FAMILY MEMBER?* ☐ NO ☐ YES *IF YES, INDICATE NAME AND LOCATION OF ALLERGIST*

## FOR ALLERGY DEPARTMENT USE

Dr. Mark H. Schecker
Allergist

# Coastal Carolina Allergy & Asthma Associates, P.C.

Fellow American Academy of Allergy, Asthma & Immunology

Fellow American College of Allergy, Asthma & Immunology

Date _____

Dear Parent/Legal Guardian:

It is our office policy that a parent or legal guardian brings his/her child to the initial office visit, allergy testing visits and visits for certain medical procedures. We understand that circumstances may arise when another adult family member or adult friend will have to bring your child into the office for a follow up visit. In this case, we must have parent/guardian authorization to see the child.

In order for us to provide the best medical care, the adult accompanying the child must know the patient's medical history in detail. This includes a complete list of medications and dosages the child currently takes as well as the reason for the visit. In addition, the patient's primary caregiver must be available by telephone to speak with Dr. Schecker at the time of the visit.

Please Complete and sign:

I _____ parent/legal guardian authorize the following individual (s) listed below to bring my child _____ DOB _____ for treatment or allergy injections and assume responsibility for their care during this time. I also assume responsibility to notify Coastal Carolina Allergy & Asthma Associates whenever this information changes. This form shall be effective until it is canceled by the parent/legal guardian.

Parent or Guardian _____

Authorized Individuals are stated below

| | |
|---|---|
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |

3516 Caduceus Drive • Myrtle Beach, SC 29588
Phone: (843) 293-0093 • Fax: (843) 293-0096

# Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

COASTAL CAROLINA ALLERGY _____ is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

| **Check each person/entity approved to receive information.** | Check type of information that can be given to person/entity on the left in the same section. |
|---|---|
| ☐ Voice Mail | ☐ Results of lab tests/x-rays<br>☐ Other_____ |
| ☐ Other person (s) (provide name and phone number) | ☐ Financial<br>☐ Medical |
| ☐ Email communication-Provide email address*<br>_____<br>*For email communication to occur, please accept the disclosure below: | ☐ Financial<br>☐ Medical<br>☐ Appointment reminders<br>☐ Breach notification |
| ☐ Text communication – Provide number *<br>_____<br>*For text communication to occur, accept the disclosure below: | ☐ Appointment reminder<br>☐ Other: _____ |
| ☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected. | |
| ☐ Photo of patient received by patient or legal guardian<br>☐ Photo taken by staff (Example: pre/post procedure)<br>☐ Other | ☐ May be posted in office<br>☐ May be posted on website<br>☐ Other_____ |

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____
Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

Complete Both Sides

# Authorization to Release Health Information

**Patient Information:**

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

**At my request,** COASTAL CAROLINA ALLERGY _____ **may release the following information:**

(Name of the entity)

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Marketing*
- ☐ On site record review by the patient
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
- ☐ Diagnostic studies (list):

- ☐ Other as listed

*Financial compensation is received for this communication.

**Entity or person who will receive the information:**

Name _____

Address _____

City, State, Zip _____ Phone _____

☐ **Send the information electronically. Email address:** _____

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

**This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.**

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2014

Complete Both Sides

*Coastal Carolina Allergy and Asthma Associates*

New Patient - Referral Source

**Today's Date:** _____

**First Name** _____ **M.I.** _____ **Last name** _____

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**How did you learn about Dr. Schecker and Coastal Carolina Allergy & Asthma Associates?**

- ☐ Doctor Referral — Doctor's Name _____
- ☐ Family Member — Relative's Name _____
- ☐ Friend — Friend's Name _____
- ☐ Newspaper Story
- ☐ Magazine Story
- ☐ Advertisement
- ☐ Yellow Pages / Phone Directory
- ☐ Internet Search
- ☐ Other — Describe _____

**Do you read any of the following publications?**

- ☐ *SC Woman* magazine
- ☐ *Parent News* magazine
- ☐ *The Sun News*
- ☐ *Transitions* magazine
- ☐ *Healthy & Longevity* magazine
- ☐ *The Horry Independent*
- ☐ *Myrtle Beach Herald*
- ☐ *Horry County Business Journal*

# COASTAL CAROLINA ALLERGY AND ASTHMA ASSC.,PC

## DR. SCHECKER

**PATIENT NAME**_____**DATE**_____

### Medication Chart

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

| **Prescriptions** | | | | | |
|---|---|---|---|---|---|
| **Name of medicine** | **Dose** (total milligrams) | **How many times per day?** | | **Who prescribed it for you?** (Physician's last name) | **Why do you take it?** |
| | | | | | |
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| **Over-the-counter medications, herbal remedies, vitamins** | | | | | |
|---|---|---|---|---|---|
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Update this every time you visit.